Distinct Elements List (DW1)	
Element	**Brief Description**
Ace Inhibitor Fill	Was an ACE INHIBITOR filled at our pharmacy for this patient, this visit? Relies on the DM AUDIT ACE INHIBITORS taxonomy being in place and populated. (Y/N)
Admission Service	The Service Code to which the patient was admitted. If patient stays in that Service for the entire hospitalization, they he/she receives the same code as the Discharge Service. Not used for outpatient or dental visits.
Admission Type	Admission type.
ADA Code Fee	Fee for this ADA Code rounded to the nearest dollar
ADA Units	Number of units... of what?
Any Field in this Subset Modified Since Last Exported?	Field used by the source system to indicate to the DW how to process this subset of records.
Attending Physician Affiliation Code	The affiliation of the attending physician.
Attending Physician Discipline Code	The discipline code of the attending physician.
Attending Physician Local Code	The code used at the site to identify the attending physician. Usually, but not always the physician's initials.
Beneficiary Classification Code	Classification Code from the Standard Codebook. May be used to "link" visit to registration.
Blood Quantum Code	The code for the Indian Blood Quantum of the patient.
Cause of Death	ICD code for cause of death.
Cause of Diagnosis	(1-Hospital acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 1)
Cause of Injury	ICD9 E code for the cause of the injury. (Only used if diagnosis code is between 800 and 999.9, meaning injury.)
Chart Facility Code	Facility code where the chart is located.
Chart Number	A patient's health record number (HRN). May be used to "link" visits to registration information.
Chart Status Code	A set of codes based on the RPMS "Patient" file. It tells us the status of the chart in the source system. (A=Active, I=Inactive, D=Deleted)
CHS Cost	For CHS visits, total cost information.
City	The city or town of the patient. This is the mailing address of the patient.
Clinic Code	Clinic code assigned to the visit.
Clinical Measure Code	Code describing the type of measurement that is being captured. (1=Height, 2=Weight, 4=Blood Pressure.)
Clinical Measure Result Value	This field will be used for Blood Pressure, Height, & Weight. BP to be reported in ###/### format, height to be output in inches in ##.# format, weight in pounds in ###.# format.
Community of Residence Code	The code for the State/County/Community of Residence of the patient. May be used to "link" visit to registration.
Coverage Type Code	The type of coverage for which the patient is eligible.
CPT Code	CPT code for the procedure.
CPT Quantity	CPT Quantity
Data Entry Creation Date (character format)	Date data entry first ætouchedÆ the visit. Will be available prospectively only. Character field formatted as CCYYMMDD.

Date Moved To Community (character format)	This is the date when the patient first moved to this community of residence. Character field formatted as CCYYMMDD.
Date of Birth (character format)	Patient's Date of Birth - received from patient registration information. Character field formatted as CCYYMMDD.
Date of Death (character format)	Patient's Date of Death - received from patient registration information. Character field formatted as CCYYMMDD.
Date of Last Update	Date last modified by the local registration system.
Day of Week	Day Of Week the visit / admission occurred. (0=Sunday, 1=Monday, etc.)
Dental Cost	Dental Total Cost rounded to the nearest dollar.
Dental Delivery Code	Used exclusively by dental to indicates if the visit was Direct or Contract. (D or K)
Dental Operative Site	A code used to identify the tooth, range of teeth, or other location for which the ADA procedure was performed.
Dental Tooth Surface	Tooth Surface is a code used to identify the surface of the tooth for which the ADA procedure was performed.
Dentist's SSN	SSN for the dental provider. (format 999999999, no dashes)
Diagnosis Code (Purpose of Visit)	Purpose of Visit ICD diagnostic code. The diagnosis with sequence 1 is considered the primary diagnosis.
Diagnosis Sequence Number	the sequence number of the diagnosis for which the CPT procedure was performed, if applicable. It is used to "join" this PROCEDURE record to the DX record.
Discharge Date (character format)	Inpatient visit: date patient discharged. Outpatient visit: null. Character field formatted as CCYYMMDD.
Discharge Service Code	The Service Code to which the patient was discharged. If patient stays in that Service for the entire hospitalization, they he/she receives the same code for both Admission and Discharge Service.
Discharge Type Code	Identifies how a patient was discharged from an inpatient (i.e., hospital) visit.
Disposition On ER Visits	If this is an ER visit, what is the disposition code?
DM Nutrition Education	Was Diabetes Mellitus education given to the patient? (Y/N)
Education Code	Patient Education Topic.
Education Understanding	Education - patient's level of understanding ('1' For Poor; '2' For Fair; '3' For Good; '4' For Group-No Assessment; '5' For Refused).
Eligibility End Date (character format)	For Medicaid and Medicare this will be the eligibility end date; for private insurance this will be the expiration date. Character field formatted as CCYYMMDD.
Eligibility Start Date (character format)	Date that eligibility for the specific type of coverage begins. For Medicaid and Medicare this will be the eligibility date; for private insurance this will be the effective date. Character field formatted as CCYYMMDD.
Eligibility State Code	Used to identify the state where a patient is eligible for Medicaid.
Encounter Delete Flag	This flag indicates if the visit was deleted from the local system.
Encounter Export Date	-
Evaluation and Management CPT Code	CPT code from evaluation and management field of visit file.
Export Log Number	This is the control number assigned to the export at the local level. It will allow us to track the data back to the facility. It is specific to RPMS, but non-RPMS systems may also have a local batch control/log number that we can use for the same purpose.
Father's First Name	Father's First Name.
Father's Last Name	Father's Last Name.

Father's Middle Name	Father's Middle Name.
Fecal Occult Blood Lab	This Fecal Occult Blood lab test will be stored in the LAB_TEST table with LOINC code 2335-8.
First Modified Date i.e., Export Begin Date (character format)	This is the Begin Date of the date range used by the site to export data to the warehouse. Character field formatted as CCYYMMDD.
First Name	The first name of the patient; could also be an alias.
Full Name	The patient's name prior to parsing into first, middle, last, etc. The format is specific to the local system.
Gender	Sex of Patient as provided by the patient's registration information.
Glucose Value	This Glucose lab test will be stored in the LAB_TEST table with LOINC code 2345-7.
HDL Cholesterol Test	HDL Cholesterol Test (Y/N)
HDL Cholesterol Value	This HDL Cholesterol lab test will be stored in the LAB_TEST table with LOINC code 2085-9.
Health Factor Category	Health factor category, e.g., "Tobacco."
Health Factor Code	Health Factor code.
Health Factor Name	Name of Health Factor, e.g., "previous smoker"
Health Factory Category Code	Health factor category code.
HGB A1C Value	This HgbA1C lab test will be stored in the LAB_TEST table with LOINC code 4548-4.
HL7 Immunization Code	IHS's proprietary subset of HL7 codes used for immunization identification.
HTN Ever Documented Flag	If Hypertension (HTN) was ever documented as a Purpose of Visit (POV), this flag is set to Y, otherwise it is N.
HTN Last Documented (character format)	Date Hypertension (HTN) last documented as a Purpose Of Visit (POV). Character field formatted as CCYYMMDD.
ICD9 Procedure Code	-
IHS Immunization Code	Old IHS immunization code
Immunization Dose Number Code	Some immunizations require multiple doses over a period of time. This field keeps track of which dose in the series was provided on this visit. (Not necessarily a number.)
Infection Flag	Infection Flag (Y/N)
Insurance Category Code	Type of Eligibility (MCD=Medicaid, MCR=Medicare, RRE=Railroad Retirement, PVT=Private Insurance)
Insurer EIN	Insurer's Employer Identification Number
Insurer Name	Usually the name of the insurance company.
Lab Test Name	Lab test name as stored in the local system.
Last Menstrual Period (character format)	Last known menstrual period on file. (Note: this may not be current. Check against date noted.) Format: CCYYMMDD
Last Modified Date i.e., Export End Date (character format)	This is the End Date of the date range used by the site to export data to the warehouse. Character field formatted as CCYYMMDD.
Last Name	The last name of the patient; could also be an alias.
LDL Cholesterol Test	LDL Cholesterol Test (Y/N)
LDL Cholesterol Value	This LDL Cholesterol lab test will be stored in the LAB_TEST table with LOINC code 2089-1.
Length of Education	The amount of time, in minutes, that it took to provide the education to the patient.
Length of Stay	Number of days patient in hospital.
LMP Noted (character format)	Date last menstrual period was noted. Format: CCYYMMDD

Local SSN Verification Code	When the facilities use the SSA information to update their local databases, they assign their own verification match codes to the data and include it in the export to DW. We use this field to store this information.
Location of Encounter	Facility code for the location where the visit took place.
LOINC Code	Logical Observation Identifiers Names and Codes (LOINC«). Nationally recognized standard code set to identify the lab test.
Mailing Address Street	The street address, P.O. box, or rural route address of the patient. This is the mailing address.
Mailing Address Street	The street address, P.O. box, or rural route address of the patient. This is the mailing address.
Medication Name	Name of the medication as stored in the local system.
Medication NDC Code	National Drug Code (NDC) for this medication.
Medication Quantity	Quantity. A number up to 9999999.999
Microalbuminuria Flag	Was the Microalbuminuria test performed? (Y/N)
Microalbuminuria Value	Value of the Microalbuminuria test.
Middle Name	The middle name of the patient; could also be an alias.
Midwifery Flag	This flag indicates if the provider is a midwife.
Mother's Maiden First Name	Mother's First Name
Mother's Maiden Last Name	Mother's Maiden Last Name
Mother's Maiden Middle Name	Mother's Middle Name
Name of Exporting Box's Site	Name of Exporting Box's Site
Name Suffix	Name suffix, such as Sr., Jr., III, etc.
Number of Consults	Number of consults during an inpatient stay.
Number of Lab Tests Done	This is the number of lab tests that were performed for this visit. It may not match the number of rows in the lab test table because we are only tracking a subset of lab tests results for DW-1.
Number of PCC Visits	The total number of pcc visits that are contained in this export.
Pap Lab Test	This Pap Smear lab test will be stored in the LAB_TEST table with LOINC code 19762-4. (Y/N)
PCC Visit Errors	Number of PCC visits skipped (not exported) due to error.
PCC Visits Skipped	Total number of PCC visits skipped (not exported).
PHN Activity Code	Activity Code used for reporting PHN visits. (01=Home, 02=Other, 03=Patient not found)
PHN Activity Minutes	Total number of minutes to complete the activity.
PHN Intervention Level (P=primary, S=secondary, T=tertiary)	Level of Intervention code used of Public Health Nursing reporting.
PHN Travel Minutes	Travel Time recorded in minutes.
Place of Injury	Code for the place of injury. (Only used if diagnosis code is between 800 and 999.9, meaning injury.)
Plan Name	Plan Name for Medicaid Coverage. Applicable Only for Medicaid
Policy Holder's First Name	The first name of the insurance policy holder.
Policy Holder's Last Name	The last name of the Insurance Policy holder.
Policy Holder's Middle Name	The middle name of the insurance policy holder.
Policy Number	Policy Number
Policy Prefix/Suffix	Use to store policy suffix for Medicare, or prefix for Railroad Retirement
Procedure Date (character format)	Date the procedure took place. (CCYYMMDD format).

Provider Affiliation Code	Provider Affiliation Code.
Provider Class Code	-
Provider Discipline Code	Provider Discipline Code.
Provider Local Code	The code used at the site to identify the provider. Usually, but not always the provider's initials.
Provider Spec Code	-
Provider Type Code	Provider (a.k.a. Vendor) Type Code; a vendor is a provider that is contracted by IHS; we only receive provider type code for contract visits; there should only be one per visit, so it will be stored with the primary (and only) provider for this contract visit.
Provider Type Code	-
PSA Lab Test	This Prostate Specific Antigen lab test will be stored in the LAB_TEST table with LOINC code 2857-1.
Range Lower Limit	Used for lab results that have a range of values.
Range Upper Limit	Used for lab results that have a range of values.
Registration Record Create Date (character format)	The date that the registration record was created on the local system. Character field formatted as CCYYMMDD.
Registration Status Code (A=active, I=inactive)	Indicates the status of a patient registration and all of its components, i.e. demographic states, charts, aliases, and insurance eligibilities. (Examples why inactive: death of patient, or registration consolidated with another for same patient.)
Relationship to Insured	Patient's relationship to the insured - applicable only for Medicaid and Private insurance. This will be the applicable code for ôrelationship to insuredö used by UB-92, a nationally recognized standard for electronic claims submission.
Sequence Number	-
Service / Admission Date (character format)	Outpatient visit: date of service. Inpatient visit: admission date. Character field formatted as CCYYMMDD.
Service Category Code	Used to identify the type of visit. For example, H=Hospital, C=Chart Review.
Service Eligibility Code	Shows if a patient is eligible for ANY IHS services. (C=CHS & Direct; I=Ineligible; D=Direct only; P=Pending Verification. Note: Native Americans cannot be coded "ineligible.") May be used to "link" visit to registration.
Service Level Code	Level of Service code.
Service Type Code	Type of Visit: I=IHS; C=Contract; T=Tribe-Non 638/Non-Compact; O=Other; 6=T ("Other" is used for anything usually done outside of IHS. For example, if a visit is recorded for a surgical procedure done historically or at a facility outside of IHS, then Other is used);
Skipped Demo Patients	Number of PCC visits not exported because the patient's name was DEMO, PATIENT.
Social Security Number Pseudo-code	Field used by the load process to determine if the SSN is actually a pseudo-ssn assigned by the facility.
Source File Export Date (character format)	Date the export was run at the facility. Character field formatted as CCYYMMDD.
Source File Record Quantity	Total number of records contained in the source file, i.e., the file the IE receives from the facility. This should be the number of HL7 messages.
State Code	Two digit state code. This is the mailing address of the patient.
Static ASUFAC of Exporting Box	Code used to identify the actually machine where the data originated from.
Time of Day	-
Title	Title, such as Mr., Ms., Mrs., Miss, etc.
Transfer Facility Code	Discharge To location code

Tribe Code	The code for the Indian tribe of the patient. May be used to "link" visit to registration.
Triglyceride Value	This Triglycerides lab test will be stored in the LAB_TEST table with LOINC code 2571-8.
Tryglyceride Test	-
Unique Encounter ID	A unique encounter (visit) record ID generated by RPMS or other patient care system.
Unique Registration Code	A unique registration record ID generated by RPMS or other registration system. (The primary key of the REG.PAT_REG table.) It is unique per registration record, not per patient.
Unique Registration Database ID	This code is intended to identify the database where the data originated from. Its main function is to be used as an audit trail in the event we need to troubleshoot some data. It is a 6-character ID agreed upon between the sending application and DW
Unit of Measure	Unit of Measure
Urine Protein Test Flag	Was Urine Protein Test performed? (Y/N)
Urine Protein Value	Value of the Urine Protein test.
VA Drug Class Code	VA Drug Class Code (formatted XX999)
Zip Code	This is the zip code for the mailing address.
Zip Code Extension	The additional 4-characters that follow the 5-character zip code, if available.